



1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amended After Comments)

5 907 KAR 1:604. Recipient cost-sharing.

6 RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020,  
7 42 C.F.R. 430.10, 431.51, 447.15, 447.20, 447.21, 447.50, 447.52, 447.54, 447.55, 447.56, 447.57,  
8 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C.  
9 1396a, 1396b, 1396c, 1396d, 1396e, 1396f-6, 1396f-8, 1396u-1, 1397aa -1397jj

10 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5),  
11 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.90, 457.535, 457.560, 42 U.S.C. 1396f-6(b)(5)

12 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
13 Services, Department for Medicaid Services has responsibility to administer the Medicaid  
14 Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any  
15 requirement that may be imposed, or opportunity presented, by federal law to qualify for federal  
16 Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations  
17 that implement copayments for Medicaid recipients. This administrative regulation establishes the  
18 provisions relating to Medicaid Program copayments.

19 Section 1. Definitions. (1) ~~["Community spouse" means the individual who is married to~~  
20 ~~an institutionalized spouse and who:~~

21 ~~—(a) Remains at home in the community; and~~

1 ~~—(b) Is not:~~

2 ~~—1. Living in a medical institution;~~

3 ~~—2. Living in a nursing facility; or~~

4 ~~—3. Participating in a 1915(c) home and community based services waiver program.~~

5 ~~—(2)]~~ "Copayment" means a dollar amount representing the portion of the cost of a Medicaid  
6 benefit that a recipient is required to pay.

7 (2) [(3)] "Department" means the Department for Medicaid Services or its designee.

8 (3) [(4)] ~~"Dependent child" means a child, including a child gained through adoption, who:~~

9 ~~—(a) Lives with the community spouse; and~~

10 ~~—(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.~~

11 ~~—(5) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.~~

12 ~~—(6) "Drug" means a covered drug provided in accordance with 907 KAR 23:010 for which~~  
13 ~~the Department for Medicaid Services provides reimbursement.~~

14 (7)] "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

15 (4) [(8)] ~~"Federal Poverty Level" or "FPL" means guidelines that are updated annually in~~  
16 ~~the Federal Register by the United States Department of Health and Human Services under~~  
17 ~~authority of 42 U.S.C. 9902(2).~~

18 ~~—(9) "KCHIP" means the Kentucky Children's Health Insurance Program.~~

19 (10)] "Managed care organization" or "MCO" means an entity for which the Department for  
20 Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R.  
21 438.2.

22 (5) [(11)] "Medicaid Works individual" means an individual who:

23 (a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B)

would be considered to be receiving supplemental security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

~~(6)(12) "Nonemergency" means a condition that does not require an emergency service pursuant to 42 C.F.R. 447.54.~~

~~—(13) "Office visit for behavioral health care" means a visit to a clinician or prescriber in which a:~~

~~—(a) Diagnosis of a behavioral health condition is made;~~

~~—(b) Treatment decision related to the diagnosis of a behavioral health condition is continued; or~~

~~—(c) Prescription for a behavioral health condition is:~~

~~—1. Initially issued; or~~

~~—2. Renewed.~~

~~(14)~~ "Recipient" is defined ~~by~~<sup>in</sup> KRS 205.8451(9).

~~[(15) "Visit" means:~~

~~—(a) 1. An encounter; or~~

~~—2. A series of encounters that are performed on the same date of service at the same~~

1 **physical location;**

2 ~~—(b) Between a recipient or enrollee and a health care provider during which time a covered~~  
3 ~~service is delivered; and~~

4 ~~—(c) A service that occurs:~~

5 ~~—1. In person; or~~

6 ~~—2. Via telehealth if authorized by 907 KAR 3:170.]~~

7 Section 2. ~~[Copayments. (1) The following table shall establish the:~~

8 ~~—(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost~~  
9 ~~sharing pursuant to Section 3(1) and (2) of this administrative regulation; and~~

10 ~~—(b) Corresponding provider reimbursement deductions.~~

Benefit	Copayment Amount
<del>Acute</del> <del>inpatient</del> <del>hospital</del> <del>admission</del>	\$50
<del>Outpatient</del> <del>hospital</del> <del>or</del> <del>ambulatory surgical center visit</del>	\$4
<del>Emergency</del> <del>room</del> <del>for</del> <del>a</del> <del>nonemergency visit</del>	\$8
<del>DMEPOS</del>	\$4
<del>Podiatry office visit</del>	\$3
<del>Chiropractic office visit</del>	\$3
<del>Dental office visit</del>	\$3
<del>Optometry office visit</del>	\$3

<del>General ophthalmological office visit</del>	<del>\$3</del>
<del>Physician office visit</del>	<del>\$3</del>
<del>Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife</del>	<del>\$3</del>
<del>Office visit for behavioral health care</del>	<del>\$3</del>
<del>Office visit to a rural health clinic</del>	<del>\$3</del>
<del>Office visit to a federally qualified health center or a federally qualified health center look-alike</del>	<del>\$3</del>
<del>Office visit to a primary care center</del>	<del>\$3</del>
<del>Physical therapy office visit</del>	<del>\$3</del>
<del>Occupational therapy office visit</del>	<del>\$3</del>
<del>Speech language pathology services office visit</del>	<del>\$3</del>
<del>Laboratory, diagnostic, or radiological service</del>	<del>\$3</del>
<del>A Medicaid or KCHIP beneficiary</del>	<del>\$0</del>

<del>who is younger than nineteen (19)</del> years of age	
Brand name drug	\$4
Generic drug	\$1
Brand name drug preferred over generic drug	\$1
Pharmacy product class: certain antipsychotic drugs	\$1
Pharmacy product class: contraceptives for family planning	\$0
Pharmacy product class: tobacco cessation	\$0
Pharmacy product class: diabetes supplies, blood glucose meters	\$0
Pharmacy product class: Diabetes supplies, all other covered diabetic supplies	\$4 for first fill, \$0 for second fill and beyond, per day
Pharmacy patient attribute: pregnant	\$0
Pharmacy patient attribute: long-	\$0

<del>term care resident</del>	
<del>Pharmacy patient attribute:</del> <del>under eighteen (18) years of age</del>	<del>\$0</del>
<del>KI HIPP participant</del>	<del>\$0]</del>
<del>[Kentucky HEALTH: Medically</del> <del>Frail</del>	<del>\$0</del>
<del>Kentucky HEALTH: Former Foster</del> <del>Care Youth up to 26 years of age</del>	<del>\$0</del>
<del>Kentucky HEALTH: enrollee</del> <del>current on premiums</del>	<del>\$0]</del>

~~[(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement.~~

~~—(3) The maximum amount of cost sharing shall not exceed five (5) percent of a family's income for a quarter.~~

~~—Section 3.] Copayment General Provisions and Exemptions. (1) The department or any MCO shall not utilize or require cost-sharing or copayments in the delivery of Medicaid services within the Commonwealth.~~

~~(2) [(a) A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age shall be exempt from the copayment or cost sharing requirements established pursuant to this administrative regulation.~~

~~—(b) A beneficiary receiving services via a 1915(c) home and community based waiver shall not be subject to cost sharing established pursuant to this administrative regulation.~~

1 ~~—(c) A beneficiary receiving services in a long term care facility shall not be subject to cost-~~  
2 ~~sharing established pursuant to this administrative regulation.~~

3 ~~—(d) In response to a declared emergency relating to or rationally related to healthcare or~~  
4 ~~public health, the department may waive or direct the waiving of all required cost sharing~~  
5 ~~for all Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries not already~~  
6 ~~exempted from this administrative regulation, including a geographic or age-related~~  
7 ~~subpopulation.~~

8 ~~—(e) In response to a contracted actuarial analysis demonstrating cost effectiveness or cost-~~  
9 ~~neutrality, the department may waive or direct the waiving of all cost sharing for all~~  
10 ~~Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries not already exempted~~  
11 ~~from this administrative regulation, including a geographic or age-related subpopulation. As~~  
12 ~~necessary, the department shall seek federal financial participation and approval to~~  
13 ~~implement this paragraph.~~

14 ~~—(2)(a) A copayment shall not be imposed for a service, prescription, item, supply,~~  
15 ~~equipment, or any type of Medicaid benefit provided to a foster care child or a pregnant~~  
16 ~~woman.~~

17 ~~—(b) The department shall impose no cost sharing for an individual or recipient who is~~  
18 ~~exempt pursuant to 42 C.F.R. 447.56.~~

19 ~~—(c) A provider shall not deny services to a recipient who:~~

20 ~~—1. Makes less than or equal to 100 percent of the federal poverty level even if the recipient~~  
21 ~~cannot pay any required cost sharing; or~~

22 ~~—2. Makes more than 100 percent of the federal poverty level if:~~

23 ~~—a. The recipient cannot pay any required cost sharing; and~~



~~b. The provider does not have a policy that applies to all patients that allows for denial of services upon nonpayment of a cost sharing obligation.~~

~~(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined by [in] [42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor, or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.~~

~~(4) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).~~

~~(5)(a) Any amount of uncollected copayment by a provider from a recipient with income above 100 percent of the Federal Poverty Level at the time of service provision shall be considered a debt to the provider if that is the current business practice for all patients.~~

~~(b) Any amount of uncollected copayment by a provider from a recipient with income at or below 100 percent of the Federal Poverty Level at the time of service provision shall not be considered a debt to the provider.~~

~~(6)] A provider shall[:~~

~~(a) Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation or have a written process for attempting to collect the copayment;~~

~~(b) Not waive a copayment obligation as imposed by the department for a recipient;][and]~~

~~[(c) Document each attempt to collect the copayment or collect a copayment at the time a benefit is provided or at a later date not to exceed six (6) months from the date of provision of the service; and~~

~~(d)] not collect a copayment from an enrollee for a service or item if a copayment is not imposed~~

1 for that service or item.

2 ~~[(7) Cumulative cost sharing for copayments for a family with children who receive~~  
3 ~~benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of~~  
4 ~~the annual family income.~~

5 ~~—(8) In accordance with 42 C.F.R. 447.15 and 447.20, the department shall not increase its~~  
6 ~~reimbursement to a provider to offset an uncollected copayment from a recipient.]~~

7 Section 3[4]. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual  
8 shall pay a monthly premium that is:

- 9 1. Based on income used to determine eligibility for the program; and  
10 2. Established in paragraph (b) of this subsection.

11 (b) The monthly premium shall be:

- 12 1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no  
13 more than 150 percent of the FPL;  
14 2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no  
15 more than 200 percent of the FPL; and  
16 3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more  
17 than 250 percent of the FPL.

18 (2) An individual whose family income is equal to or below 100 percent of the FPL shall not  
19 be required to pay a monthly premium.

20 (3) A Medicaid Works individual shall begin paying a premium with the first full month of  
21 benefits after the month of application.

22 (4) Benefits shall be effective with the date of application if the premium specified in subsection  
23 (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling.

**~~[Section 5. Provisions for Enrollees. A managed care organization:]~~**

~~—(1) Shall not impose a copayment on an enrollee that exceeds a copayment established in this administrative regulation; and~~

~~—(2) May impose on an enrollee:~~

~~—(a) A lower copayment than established in this administrative regulation; or~~

~~—(b) No copayment.]~~

Section ~~4~~**6**. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

1 Section 5[7]. Appeal Rights. An appeal of a department decision regarding the Medicaid  
2 eligibility of an individual shall be in accordance with 907 KAR 1:560.

3 Section 6[8]. [~~Applicability of KAR Title 895. If eligible for Kentucky HEALTH, an individual~~  
4 ~~subject to this administrative regulation shall also comply with any applicable requirements~~  
5 ~~established pursuant to KAR Title 895.~~

6 ~~—Section 9.]~~ Federal Approval and Federal Financial Participation. The department's copayment  
7 provisions and any coverage of services established in this administrative regulation shall be  
8 contingent upon:

9 (1) Receipt of federal financial participation; and

10 (2) Centers for Medicare and Medicaid Services' approval.

11 Section 7[9][40]. This administrative regulation was found deficient by the Administrative  
12 Regulation Review Subcommittee on May 13, 2014.

REVIEWED:

Label

APPROVED:

  
Eric Friedlander, Secretary

Eric Friedlander, Secretary  
Cabinet for Health and Family Services

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;  
and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation filed March 13, 2020, exempts 1915(c) Medicaid members and Medicaid members who receive services within a long-term care facility from Medicaid co-pays, waives co-payments under circumstances relating to an emergency declaration, and clarifies additional circumstances where the department may waive copayments in response to an actuarial analysis if any needed federal approval is received. The amendment also more clearly exempts pregnant women from co-pays to reflect current department practice and interpretation of federal regulation. The amendment also will allow for a managed care organization to reduce or eliminate an enrollee's requirement to pay a copay, and prohibit a provider from collecting a copayment for a service or item if a copayment is not imposed. The amendment also removes references to the Kentucky HEALTH program in the table of copayments.

The Amended After Comments version of this administrative regulation removes all copays and cost-sharing from the Medicaid program. The department is making this change after analyzing encounter data and provider and member experiences. The cost-sharing requirements within this administrative regulation have functioned as a rate reduction and administrative cost on Kentucky's providers. More importantly, the existence of co-pays and cost-sharing requirements have not served to make Medicaid members healthier or provide better access to care.

The department anticipates that these changes will encourage recipients to improve

treatment adherence and have improved health outcomes. Furthermore, the complex interplay of federal requirements and exemptions stemming from this administrative regulation and the volatile nature of many incomes around 100% of the Federal Poverty Level (FPL) have created great difficulty for members, providers, and plan administrators. Currently, only a narrow group of recipients whose incomes are within 100%-138% of the FPL are required to pay co-pays and can be turned away by providers if they do not pay. The IT and personnel costs to monitor who is within that income range are prohibitively expensive for providers, managed care organizations, and the department.

Finally, some providers and MCOs allege that there are certain categories of Medicaid members, such as pregnant women, who continue to have inappropriate co-pays applied. This could lead to the delaying of care by members, such as the beginning prenatal care regimens. For these reasons, and others, the department is removing copays and cost-sharing in order to facilitate a more efficient and responsive Medicaid program for members, providers, and administrators.

- (b) The necessity of the amendment to this administrative regulation: The amendments to this administrative regulation are necessary to remove copayments within the Medicaid program to respond to concerns highlighted and brought into greater relief via the administrative regulation comment process.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by removing copayments and establishing certain protections for members and providers relating to copayment obligations in order to improve access to care and facilitate a more efficient and responsive Medicaid program
  - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes by instituting a clear policy prohibiting the use of copayments in the Medicaid program.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid recipients who may be subject to cost sharing may be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied. The department estimates that up to 800,000 Medicaid members may be impacted by this administrative regulation. By removing all co-pays, DMS also anticipates that 46,000 Medicaid providers will no longer experience reduced rates or administrative costs in pursuing payment for nominal co-pays.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Enrollees, recipients, and providers will need to not assess or collect copayments in order to comply with the changes made to the administrative regulation.

- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Enrollees and recipients will incur no costs in complying with this administrative regulation.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Enrollees, recipients, and providers will be able to participate fully in the Medicaid program.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The Department for Medicaid Services (DMS) anticipates increased up-front costs reflected in an increase in MCO capitation rates on an initial basis. The increased rates will be necessary to fully pay providers Medicaid rates without an anticipated co-payment subtracted. Increased up-front costs due to slight rate reimbursement increases may also be reflected in DMS' administration of the Fee-For-Service program. In addition to seeing a slight increase in reimbursement, Medicaid providers will also experience a decrease in administrative burden associated with collection of copayments. By improving treatment adherence and removing a barrier to care for many low-income recipients, DMS anticipates that these costs will be neutralized by health care that is delivered more efficiently, timely, and comprehensively. Furthermore, DMS may experience administrative savings or cost shifts due to reducing oversight of co-pay obligations of members making around 100% FPL.
  - (b) On a continuing basis: The Department for Medicaid Services (DMS) anticipates increased up-front costs reflected in an increase in MCO capitation rates on a continuing basis. The increased rates will be necessary to fully pay providers Medicaid rates without an anticipated co-payment subtracted. Increased up-front costs due to slight rate reimbursement increases may also be reflected in DMS' administration of the Fee-For-Service program. In addition to seeing a slight increase in reimbursement, Medicaid providers will also experience a decrease in administrative burden associated with collection of copayments. By improving treatment adherence and removing a barrier to care for many low-income recipients, DMS anticipates that these costs will be neutralized by health care that is delivered more efficiently, timely, and comprehensively. Furthermore, DMS may experience administrative savings or cost shifts due to reducing oversight of co-pay obligations of members making around 100% FPL.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendments to this administrative regulation neither establish nor increase any fees.



- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is no longer appropriate in this administrative regulation as cost sharing obligations have been removed for all members.

## FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.90, 42 C.F.R. 447.15 and 447.20, and 42 C.F.R. 438.108
2. State compliance standards. KRS 205.520(3) and KRS 194A.050(1).
3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits.

42 C.F.R. 447.50 through 447.60 also establish limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; a requirement that state Medicaid programs do not increase a provider's reimbursement by the amount of cost sharing; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations.

42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.90.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the amendment to this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.90, 42 C.F.R. 447.15 and 447.20, authorize the action taken by this administrative regulation.
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
  - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
  - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
  - (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates increased up-front costs reflected in an increase in MCO capitation rates in the first year. The increased rates will be necessary to fully pay providers Medicaid rates without an anticipated co-payment subtracted. Increased up-front costs due to slight rate reimbursement increases may also be reflected in DMS' administration of the Fee-For-Service program. In addition to seeing a slight increase in reimbursement, Medicaid providers will also experience a decrease in administrative burden associated with collection of copayments. By improving treatment adherence and removing a barrier to care for many low-income recipients, DMS anticipates that these costs will be neutralized by health care that is delivered more efficiently, timely, and comprehensively. Furthermore, DMS may experience administrative savings or cost shifts due to reducing oversight of co-pay obligations of members making around 100% FPL.
  - (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services (DMS) anticipates increased up-front costs reflected in an increase in MCO capitation rates in subsequent years. The increased rates will be necessary to fully pay providers Medicaid rates without an anticipated co-payment subtracted. Increased up-front costs due to slight rate reimbursement increases may also be reflected in DMS' administration of the Fee-For-Service program. In addition to seeing a slight

increase in reimbursement, Medicaid providers will also experience a decrease in administrative burden associated with collection of copayments. By improving treatment adherence and removing a barrier to care for many low-income recipients, DMS anticipates that these costs will be neutralized by health care that is delivered more efficiently, timely, and comprehensively. Furthermore, DMS may experience administrative savings or cost shifts due to reducing oversight of co-pay obligations of members making around 100% FPL.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF CONSIDERATION RELATING TO  
907 KAR 1:604

CABINET FOR HEALTH AND FAMILY SERVICES  
Department for Medicaid Services  
Division of Policy and Operations

Amended After Comments

I. A public hearing on 907 KAR 1:604 was not requested, and therefore, not held. However, written comments were received during the public comment period.

II. The following individuals submitted comments during the public comment period:

<u>Name and Title</u>	<u>Agency/Organization/Entity/Other</u>
Stephanie Stumbo, Acting Executive Director	Kentucky Association of Health Plans
Steve Shannon, Executive Director	Kentucky Association of Regional Programs
Sheila Schuster, Ph.D., Executive Director	Kentucky Mental Health Coalition
Kathy Adams, Director of Public Policy	Children's Alliance

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 1:604:

<u>Name and Title</u>	<u>Agency</u>
Lisa Lee, Commissioner	Department for Medicaid Services, Commissioner's Office
Stephanie Bates, Deputy Commissioner	Department for Medicaid Services, Commissioner's Office
Leslie Hoffman, Chief Behavioral Health Officer	Department for Medicaid Services, Commissioner's Office
Lee Guice, Director	Department for Medicaid Services, Division of Policy and Operations

Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services, Commissioner's Office
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#### IV. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Removal of all Medicaid co-pays.

(a) Comment: Stephanie Stumbo, Acting Executive Director of the Kentucky Association of Health Plans; Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition; Kathy Adams, Director of Public Policy for the Children's Alliance; and Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, submitted comments requesting that the department remove all co-pays and cost-sharing in the managed care and fee-for-service populations.

(b) Response: The department agrees with this request and will remove all Medicaid co-pays from the managed care and fee-for-service populations. The administrative regulation will be amended to comply.

(2) Subject: Elevation of behavioral health fee schedule to cover rate reduction and administrative costs

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs; Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition; and Kathy Adams, Director of Public Policy for the Children's Alliance, submitted comments arguing that the behavioral health fee schedule is not sufficient to cover the costs of providing care to the behavioral health recipient population. The commenters argued that this is tantamount to a provider rate reduction due to co-pay exemptions and the reduction of the co-pay from the provider reimbursement. Furthermore, providers incur administrative costs in enforcing copayments as required by the administrative regulation.

(b) Response: The department is amending the administrative regulation to remove co-payments and expects that the increased provider reimbursement and reduced administrative costs will address the commenter's concerns.

(3) Subject: Difficulty of tracking maximum member co-pays over a quarter

(a) Comment: Stephanie Stumbo, Acting Executive Director of the Kentucky Association of Health Plans, submitted comments highlighting the difficulty in tracking member co-payments over a quarter and indicating that this damages the relationship between provider, member, and MCO on an ongoing basis.

(b) Response: The department acknowledges the difficulty involved in tracking member co-payments over the course of a quarter and the impact this has on the ongoing relationships between provider, member, and MCO. It is the department's hope that removing co-pays will be an effective method in enhancing this relationship and improving the delivery of healthcare to Medicaid members.

(4) Subject: Difficulty of providing prenatal care as a result of current co-pay policies

(a) Comment: Stephanie Stumbo, Acting Executive Director of the Kentucky Association of Health Plans, submitted comments that recipients who are pregnant are often still charged co-pays. This occurrence is in contravention of federal law, and is likely due to member or provider delay in informing the department or MCO that the member is pregnant. This is a persistent problem, and is difficult to address under the current co-pay system, and has resulted in many members failing to receive important prenatal care.

(b) Response: The department agrees that pregnant members need access to prenatal care and that they should not be subjected to co-pays during any pregnancy. It is the department's expectation that by removing co-pays, that the approximately 24,000-26,000 Medicaid members who become pregnant each year will avoid all co-pays and have no restrictions in accessing prenatal care. The department further expects that this change will result in cost savings to the Medicaid program due to the increased adherence to a prenatal care regimen for pregnant members and earlier medical interventions as necessary.

(5) Subject: Any co-payment is a barrier to accessing care.

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, pointed to the presence of any copayment as a barrier to accessing care for recipients.

(b) Response: The department agrees that any copayment can be a barrier to accessing care, and will remove co-pays throughout the Medicaid program by amending the administrative regulation.

(6) Subject: Consistency of co-pays between MCOs for residential substance use disorder (SUD) treatment

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, submitted comments pointing out a split among MCOs in charged amounts for copayments for residential substance use disorder.

(b) Response: As part of the amendments to the administrative regulation, any copayment for a residential substance use disorder treatment program will be removed.

(7) Subject: Ongoing need for COVID-19 related mental health services post-pandemic that will continue for an extended period

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, submitted comments pointing out that there will be an ongoing need for COVID-19 related mental health services post-pandemic and that this will continue for an extended period.

(b) Response: The department agrees with this comment and by removing all co-pays will allow for this anticipated care to be delivered with the least complications.

(8) Subject: Volatility of income levels

(a) Comment: Stephanie Stumbo, Acting Executive Director of the Kentucky Association of Health Plans, submitted comments highlighting the volatility of income levels of Medicaid members. The income volatility of many members is difficult for MCOs and the department and causes copayment responsibilities to be difficult to track. This volatility further results in

providers, members, and MCOs having difficulty in accurately applying and monitoring copayment requirements. This tracking has become especially fraught over the previous year as a federal requirement that individuals at or below 100% FPL cannot be refused service if unable to pay a copayment was more clearly incorporated into this administrative regulation.

(b) Response: The department agrees that tracking of income and copay requirements is complex and has become more complex over the past year. By removing co-pays, the department is hopeful that recipients, providers, and MCOs will be able to better concentrate on delivering medical care to recipients.

(9) Subject: Copayments and access to care for the most vulnerable

(a) Comment: Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments stating that “significant research studies...show cost-sharing has a deleterious effect on access to needed medical services especially for the most vulnerable.” Dr. Schuster goes on to state that individuals with a behavioral health diagnosis are more likely to underuse services, regardless of the presence or absence of copayments. The consistent use of services, whether behavioral or medical, are necessary to achieve positive health outcomes.

(b) Response: The department agrees that cost-sharing has a negative effect on access to needed medical services, especially for the most vulnerable Medicaid recipients. The department hopes by fully removing cost-sharing that increased treatment adherence and outcomes will be possible for all Medicaid members.

(10) Subject: Pausing of co-pays until an actuarial analysis is conducted

(a) Comment: Steve Shannon, Executive Director of the Kentucky Association of Regional Programs, and Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, requested that all co-pays be paused until an actuarial analysis could be conducted.

(b) Response: This will not be necessary as all co-pays are being removed, and the section relating to the actuarial analysis has been deleted. However, the department originally proposed this provision as an ongoing obligation to examine the Medicaid program’s use of copayments and not as a single event. The department will not be amending the administrative regulation in response to the question.

(11) Subject: Service and provider type nuance to current copayments

(a) Comment: Stephanie Stumbo, Acting Executive Director of the Kentucky Association of Health Plans, submitted comments arguing that the department needed to incorporate certain nuances and guidance given to the MCOs recently about certain laboratory, diagnostic, and radiology billing codes to the administrative regulation.

(b) Response: As all co-pays are being removed, this will not be necessary and the department’s amendments to the administrative regulation will address the commenter’s concerns.



V. SUMMARY OF STATEMENT OF CONSIDERATION  
AND  
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:604. This administrative regulation is being amended after comments. DMS is amending the administrative regulations as follows:

Pages 1-2

Section 1(1)

Lines 19 to 21 and 1 to 5

After "(1)", delete the remainder of subsection (1) and delete the notation "(2)".

Page 2

Section 1(3)

Line 7

Before "(3)", insert "(2)".

Delete "(3)".

Page 2

Section 1(4), 1(5), 1(6), and 1(7)

Lines 8 to 14

Before "(4)", insert "(3)".

Delete subsections (4), (5), and (6), and delete the notation "(7)".

Page 2

Section 1(8), 1(9), and 1(10)

Lines 15 to 19

Before "(8)", insert "(4)".

Delete subsections (8) and (9), and delete the notation "(10)".

Page 2

Section 1(11)

Line 22

Before "(11)", insert "(5)".

Delete "(11)".

Page 3

Section 1(12), 1(13), and 1(14)

Lines 10 to 19

Before "(12)", insert "(6)".

Delete subsections (12) and (13), and delete the notation "(14)".

Pages 3 and 4

Section 1(15)

Lines 20 to 23 and 1 to 5

Delete subsection (15) in its entirety.

Pages 4-7

Sections 2 and 3

Lines 6 to 9; the table on pages 4, 5, 6, and 7; and Lines 1 to 6

After "Section 2.", delete the remainder of Section 2 and delete the notation "Section 3."

Page 7

Section 3(1)

Line 6

After "(1)", insert the following:

The department or any MCO shall not utilize or require cost-sharing or copayments in the delivery of Medicaid services within the Commonwealth.  
(2)

Pages 7 to 9

Section 3(1)(a) to (e), 3(2), 3(3), 3(4), 3(5), and 3(6)

Lines 6 to 18, 1 to 23, and 1 to 3

Beginning with "(a) A Medicaid", delete the remainder of subsection (1), delete subsections (2), (3), (4), and (5), and delete the notation "(6)".

Page 9

Section 3(6), 3(6)(a), 3(6)(b), 3(6)(c), and 3(6)(d)

Lines 3 to 11

After "provider shall", delete the colon, delete paragraphs (a), (b), and (c), and delete the notation "(d)".

Lowercase "Not".

Page 9

Section 3(7) and 3(8)

Lines 13 to 17

Delete subsections (7) and (8).

Page 9

Section 4

Line 18

After "Section", insert "3".

Delete "4".

Pages 10-11

Section 5

Lines 21-23 and 1-3

Delete Section 5 in its entirety.

Pages 10 and 11

Sections 6, 7, 8, and 9

Lines 4, 12, 14, and 22

Renumber these four (4) sections by inserting "4", "5", "6", and "7", respectively, and by deleting "6", "7", "8", and "9", respectively.